

		FOR OFF USE					

LL1

2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0042325

Facility Name: WESTSHIRE NURSING AND REHAB CTR

Address: 5825 W. CERMAK ROAD 60804
Number City Zip Code

County: COOK

Telephone Number: (708) 656-9120 Fax # (708) 656-9128

IDPA ID Number: 36-4096965

Date of Initial License for Current Owners: 09/01/96

Type of Ownership:

<input type="checkbox"/>	VOLUNTARY,NON-PROFIT	<input checked="" type="checkbox"/>	PROPRIETARY	<input type="checkbox"/>	GOVERNMENTAL
<input type="checkbox"/>	Charitable Corp.	<input type="checkbox"/>	Individual	<input type="checkbox"/>	State
<input type="checkbox"/>	Trust	<input type="checkbox"/>	Partnership	<input type="checkbox"/>	County
IRS Exemption Code		<input type="checkbox"/>	Corporation	<input type="checkbox"/>	Other
		<input checked="" type="checkbox"/>	"Sub-S" Corp.		
		<input type="checkbox"/>	Limited Liability Co.		
		<input type="checkbox"/>	Trust		
		<input type="checkbox"/>	Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA Telephone Number: (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2004 to 12/31/2004 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed)		(Date)
	(Type or Print Name)	SHELDON NEIDICH	
	(Title)	MEMBER	
Paid Preparer	(Signed)	(SEE ATTACHED ACCOUNTANTS' REPORT)	
		(Date)	
	(Print Name and Title)	BOB KAGDA PARTNER	
	(Firm Name & Address)	KRUPNICK BOKOR KAGDA & BROOKS, LTD 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124	
	(Telephone)	(847) 675-3585 Fax # (847) 675-5777	
MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630			

Facility Name & ID Number WESTSHIRE NURSING AND REHAB CTR

0042325 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>74</u>	Skilled (SNF)	<u>74</u>	<u>27,084</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>411</u>	Intermediate (ICF)	<u>411</u>	<u>150,426</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>485</u>	TOTALS	<u>485</u>	<u>177,510</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>20,085</u>	<u>1,185</u>	<u>1,959</u>	<u>23,229</u>	8
9	SNF/PED					9
10	ICF	<u>113,812</u>	<u>1,777</u>		<u>115,589</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>133,897</u>	<u>2,962</u>	<u>1,959</u>	<u>138,818</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.20%

D. How many bed-hold days during this year were paid by Public Aid? _____ (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☐ NO ☒

I. On what date did you start providing long term care at this location?
Date started 09/01/96

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 09/01/96 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☐ NO ☐ If YES, enter number of beds certified 33 and days of care provided 1,959

Medicare Intermediary ADMINISTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 12/31/2004 Fiscal Year: 12/31/2004

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number		WESTSHIRE NURSING AND REHAB CTR				#	0042325	Report Period Beginning:		01/01/2004	Ending:		12/31/2004
V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)													
	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY			
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10		
	A. General Services												
1	Dietary	580,898	49,623	20,572	651,093		651,093		651,093			1	
2	Food Purchase		483,484		483,484	(31,622)	451,862	(1,400)	450,462			2	
3	Housekeeping	399,538	117,746		517,284		517,284		517,284			3	
4	Laundry	160,987	49,325	3,499	213,811		213,811		213,811			4	
5	Heat and Other Utilities			304,635	304,635		304,635		304,635			5	
6	Maintenance	198,519	35,275	222,780	456,574		456,574	(13,885)	442,689			6	
7	Other (specify):* Security Salaries	132,337		37,235	169,572		169,572		169,572			7	
8	TOTAL General Services	1,472,279	735,453	588,721	2,796,453	(31,622)	2,764,831	(15,285)	2,749,546			8	
	B. Health Care and Programs												
9	Medical Director			21,765	21,765		21,765		21,765			9	
10	Nursing and Medical Records	3,706,423	243,043	10,666	3,960,132		3,960,132		3,960,132			10	
10a	Therapy	195,042		306	195,348		195,348		195,348			10a	
11	Activities	187,335	50,676	448	238,459		238,459		238,459			11	
12	Social Services	226,947		10,854	237,801		237,801		237,801			12	
13	Nurse Aide Training											13	
14	Program Transportation			496	496		496		496			14	
15	Other (specify):*											15	
16	TOTAL Health Care and Programs	4,315,747	293,719	44,535	4,654,001		4,654,001		4,654,001			16	
	C. General Administration												
17	Administrative	361,930			361,930		361,930	(71,179)	290,751			17	
18	Directors Fees											18	
19	Professional Services			313,018	313,018	(20,000)	293,018	(108,250)	184,768			19	
20	Dues, Fees, Subscriptions & Promotions			330,618	330,618		330,618	(265,114)	65,504			20	
21	Clerical & General Office Expenses	437,293	45,260	171,307	653,860		653,860	(208,856)	445,004			21	
22	Employee Benefits & Payroll Taxes			1,150,919	1,150,919	31,622	1,182,541		1,182,541			22	
23	Inservice Training & Education			5,431	5,431		5,431		5,431			23	
24	Travel and Seminar											24	
25	Other Admin. Staff Transportation			1,171	1,171		1,171		1,171			25	
26	Insurance-Prop.Liab.Malpractice			187,779	187,779		187,779		187,779			26	
27	Other (specify):*											27	
28	TOTAL General Administration	799,223	45,260	2,160,243	3,004,726	11,622	3,016,348	(653,399)	2,362,949			28	
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,587,249	1,074,432	2,793,499	10,455,180	(20,000)	10,435,180	(668,684)	9,766,496			29	

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE		SCHED REF	TOTAL
1	DIETARY		
	DIETITIAN CONSULTANT	XVIII B 35-2	13,440
	REPAIRS & MAINTENANCE		7,132
			0
			20,572
3	HOUSEKEEPING		
			0
			0
			0
4	LAUNDRY		
	EQUIPMENT REPAIRS & MAINTENANCE		3,499
			0
			3,499
5	HEAT & OTHER UTILITIES		
	GAS HEAT		125,048
	ELECTRICITY		116,230
	WATER		63,234
	CABLE TV - LOBBY		123
			0
			304,635
6	MAINTENANCE		
	GROUNDS MAINTENANCE		10,415
	PAINTING & DECORATING		22,452
	BUILDING REPAIRS		32,886
	MAINTENANCE TRAVEL		0
	EQUIPMENT MAINTENANCE & REPAIR		95,837
	ELEVATOR MAINTENANCE & REPAIR		52,989
	OUTSIDE LABOR		0
	EXTERMINATING SERVICE		7,869
	FIRE SERVICE		332
			0
			0
			0
			222,780
7	OTHER		
	SCAVENGER		37,235
	SECURITY SERVICE		0
			37,235
9	MEDICAL DIRECTOR		
	MEDICAL DIRECTOR FEES	XVIII B 36-2	21,765
			21,765

LINE		SCHED REF	TOTAL
10	NURSING		
	CONTRACT NURSING	XVIII C 53-2	1,965
	LABORATORY & XRAY EXPENSE		0
	PURCHASED SERVICES		0
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	2,516
	PHARMACY CONSULTANT	XVIII B 39-2	6,185
	UTILIZATION REVIEW FEES	XVIII B __-2	0
	PHYSICIANS	XVIII B __-2	0
	PSYCHIATRIC	XVIII B __-2	0
	RN CONSULTANT	XVIII B 38-2	0
			0
			0
			10,666
10a	THERAPY		
	PHYSICAL THERAPY SERVICES		0
	SPEECH THERAPY SERVICES		0
	OCCUPATIONAL THERAPY SERVICES		0
	REHABILITATION CONSULTANT	XVIII B __-2	0
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	306
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0
			306
11	ACTIVITIES		
	CABLE TV - PATIENT ROOMS		0
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	448
			0
			448
12	SOCIAL SERVICES		
	SOCIAL REHABILITATION SERVICES		0
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0
	SOCIAL WORKER	XVIII B 45-2	10,854
			0
			10,854
13	NURSE AIDE TRAINING		
	NURSE AIDE TRAINING COSTS	XIII	0
			0

V.COST CENTER EXPENSES

PAGE 3 COLUMN 3 OTHER

LINE		SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION		
	PATIENT TRANSPORTATION	496	496
17	ADMINISTRATIVE		
	MANAGEMENT FEES	XIX B 0	0
18	DIRECTORS FEES	0	0
19	PROFESSIONAL SERVICES		
	DATA PROCESSING	XIX C 29,248	
	ADMINISTRATIVE CONSULTANTS	XIX C 115,000	
	PROFESSIONAL FEES	XIX C 168,770	
		0	313,018
20	FEES,SUBSCRIPTIONS,PROMOTIONS		
	ENTERTAINMENT & MARKETING	VI 19 XIX F 0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F 250,884	
	EMPLOYEE WANT ADS	XIX F 29,733	
	CONTRIBUTIONS	VI 20 XIX F 4,660	
	DUES & SUBSCRIPTIONS	XIX F 19,528	
	LICENSES & PERMITS	XIX F 11,732	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F 0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F 0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F 0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F 9,570	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F 4,511	330,618
21	CLERICAL & GENERAL OFFICE EXPENSES		
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	1,330	
	EQUIPMENT REPAIR & MAINTENANCE	0	
	OUTSIDE CLERICAL SERVICES	0	
	PENALTIES / OVERDRAFT CHARGES	VI 18 2,036	
	HOME OFFICE EXPENSE	0	
	THEFT & DAMAGE LOSS	0	
	TELEPHONE	60,123	
	MESSENGER SERVICE	4,818	
	LAWSUIT SETTLEMENT	103,000	171,307

LINE		SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES		
	FICA TAXES	XIX D 490,300	
	UNEMPLOYMENT COMPENSATION	XIX D 135,479	
	WORKERS COMPENSATION INSURANCE	XIX D 128,357	
	HOSPITALIZATION INSURANCE	XIX D 335,089	
	EMPLOYEE BENEFITS - OTHER	XIX D 10,951	
	EMPLOYEE PHYSICAL EXAMS	XIX D 1,818	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D 0	
	PENSION/PROFIT SHARING PLANS	XIX D 48,925	
	CHICAGO HEAD TAX	XIX D 0	1,150,919
23	INSERVICE TRAINING & EDUCATION		
	EDUCATION & SEMINARS	5,431	5,431
24	TRAVEL & SEMINARS		
	EDUCATION & SEMINARS	XIX G 0	
	TRAVEL	XIX G 0	
		0	
		0	0
25	ADMIN. STAFF TRANSPORTATION		
	TRANSPORTATION - STAFF	1,171	1,171
26	INSURANCE - PROP. LIAB & MALPRACTICE		
	GENERAL INSURANCE	187,779	187,779
27	OTHER		
	BAD DEBTS	VI 24 0	
			0

GRAND TOTAL COLUMN 3 OTHER

2,793,499

WESTSHIRE NURSING AND REHAB CTR
EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
12/31/2004

TOTAL FOOD PURCHASE	483,484	PATIENT MEALS	416454
LESS SALES TAX	(1,400)	ADD EMPLOYEE MEALS	29280
	-----		-----
NET FOOD	482,084	TOTAL MEALS/YEAR	445734
TOTAL PATIENT CENSUS	138,818	NET FOOD	482084
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	445734

TOTAL PATIENT MEALS	416454	COST PER MEAL	1.08
		TIME EMPLOYEE MEALS	29280
ADD # EMPLOYEE MEALS/DAY	80		-----
TIME # DAYS	366	EMPLOYEE MEAL RECLASSIFICATION	31622
	-----		=====
TOTAL EMPLOYEE MEALS	29280		

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			88,244	88,244		88,244	660,616	748,860			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			152,939	152,939		152,939	1,579,527	1,732,466			32
33	Real Estate Taxes			758,281	758,281	20,000	778,281		778,281			33
34	Rent-Facility & Grounds			2,004,000	2,004,000		2,004,000	(2,004,000)				34
35	Rent-Equipment & Vehicles			91,818	91,818		91,818		91,818			35
36	Other (specify):* amor.-comp.soft.			21,750	21,750		21,750		21,750			36
37	TOTAL Ownership			3,117,032	3,117,032	20,000	3,137,032	236,143	3,373,175			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		69,558	213,473	283,031		283,031		283,031			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			266,266	266,266		266,266		266,266			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		69,558	479,739	549,297		549,297		549,297			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,587,249	1,143,990	6,390,270	14,121,509		14,121,509	(432,541)	13,688,968			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	10,468	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,400)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(2,036)	21		18
19	Entertainment		20		19
20	Contributions	(14,230)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(250,884)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule	(406,884)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (664,966)		\$	30

OHF USE ONLY							
48		49		50		51	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	232,425		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 232,425		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (432,541)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.
(See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

ID#0042325

Report Period Beginning:01/01/2004

Ending:12/31/2004

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ -13885	6	1
2	MARKETING SALARY	(102,490)	21	2
3	BANK CHARGES	(1,330)	21	3
4	ADMINISTRATIVE CONSULTANTS	(115,000)	19	4
5	DIRECTOR OF OPERATIONS	(71,179)	17	5
6	LAWSUIT SETTLEMENT	(103,000)	21	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(406,884)		49

Summary A

12/31/2004

[illegible]

Summary B

Facility Name & ID Number	WESTSHIRE NURSING AND REHAB CTR	#	0042325	Report Period Beginning:	01/01/2004	Ending:	12/31/2004
--------------------------------------	--	----------	----------------	---------------------------------	-------------------	----------------	-------------------

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		SOUTHVIEW MANOR	CHICAGO	EXTENDED CARE	EVANSTON	EMPL LEASING
SEE ATTACHED SCHEDULE				WESTSHIRE		
				HEALTHCARE		
				PROPERTIES	CICERO	REAL ESTATE

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENT	\$ 2,004,000	WESTSHIRE HEALTH CARE PROPERTIES		\$	(2,004,000)	1
2	V	19	ACCOUNTING FEES				6,750	6,750	2
3	V	30	DEPRECIATION				650,148	650,148	3
4	V	32	INTEREST				1,579,527	1,579,527	4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 2,004,000			\$ 2,236,425	\$ * 232,425	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number WESTSHIRE NURSING AND REHAB CTR # 0042325 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization WESTSHIRE HEALTH CARE PROPERTIES
Street Address 5825 W. CERMAK RD.
City / State / Zip Code CICERO, IL 60650
Phone Number (708) 656-9120
Fax Number (708) 656-9128

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	19	ACCOUNTING FEES	DIRECT	1	1	\$ 6,750	\$	1	\$ 6,750	1
2	30	DEPRECIATION	DIRECT	1	1	650,148		1	650,148	2
3	32	INTEREST	DIRECT	1	1	1,579,527		1	1,579,527	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 2,236,425	\$		\$ 2,236,425	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Cambridge Realty of Illiniois		X	MORTGAGE	\$145,008.00	11/22/99	\$ 20,733,500	\$ 20,047,208	11/22/39		\$ 1,579,527	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6	CIB BANK		X	WORKING CAPITAL	INTEREST	REVOLV		2,347,000	REVOLV	0.0825	152,939	6	
7												7	
8												8	
9	TOTAL Facility Related				\$145,008.00		\$ 20,733,500	\$ 22,394,208			\$ 1,732,466	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 20,733,500	\$ 22,394,208			\$ 1,732,466	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

B. Real Estate Taxes

THE PAYMENT ON LINE 2 APPLIES TO THE 2003 TAX BILL.

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO:

Long Term Care Facilities with Real Estate Tax Rates

RE:

2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

WESTSHIRE NURSING AND REHAB CTR

COUNTY

COOK

FACILITY IDPH LICENSE NUMBER

0042325

CONTACT PERSON REGARDING THIS REPORT

BOB KAGDA

TELEPHONE (847) 675-3585

FAX #: (847) 675-5777

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A)	(B)	(C)	(D)
				<u>Tax</u>
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to</u>
				<u>Nursing Home</u>
1.	<u>16-29-202-004</u>	<u>NURSING HOME</u>	\$ <u>100,690.28</u>	\$ <u>100,690.28</u>
2.	<u>16-29-202-005</u>	<u>NURSING HOME</u>	\$ <u>100,690.28</u>	\$ <u>100,690.28</u>
3.	<u>16-29-202-006</u>	<u>NURSING HOME</u>	\$ <u>201,380.56</u>	\$ <u>201,380.56</u>
4.	<u>16-29-202-007</u>	<u>NURSING HOME</u>	\$ <u>114,547.02</u>	\$ <u>114,547.02</u>
5.	<u>16-29-202-008</u>	<u>NURSING HOME</u>	\$ <u>201,278.02</u>	\$ <u>201,278.02</u>
6.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
7.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
8.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
9.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
10.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
		TOTALS	\$ <u>718,586.16</u>	\$ <u>718,586.16</u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 130,527

B. General Construction Type: Exterior MASONRY Frame Number of Stories

C. Does the Operating Entity?

☐ (a) Own the Facility

☒ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒ (a) Own the Equipment

☒ (b) Rent equipment from a Related Organization.

☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	NURSING HOME			\$ 120,000	1
2					2
3	TOTALS			\$ 120,000	3

Facility Name & ID Number WESTSHIRE NURSING AND REHAB CTR

0042325

Report Period Beginning:

01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	FOR OHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	485		1996	1972	\$ 19,609,780	\$ 502,815	39	\$ 502,815	\$	\$ 4,211,076	4
5											5
6											6
7	WESTSHIRE HEALTHCARE PROPERTIES										7
8											8
	Improvement Type**										
9	LEASEHOLD IMPROVEMENT			1996	3,490	89	39	89		712	9
10	INSTALLED 13 PHASE			1997	3,440	88	39	88		664	10
11	FURNISHED & INSTALLED GENERATOR FOR ELEVATOR			1997	7,608	195	39	195		1,471	11
12	NEW HEATER			1997	19,950	511	39	511		3,854	12
13	DRIER VENT MODIFICATIONS			1997	14,985	384	39	384		2,896	13
14	DUCTWORK			1997	9,000	231	39	231		1,742	14
15	INSTALL NEW AMPERS			1997	3,650	94	39	94		709	15
16	TOILETS, SINKS, SHOWER EQUIPMENT			1998	37,587	964	39	964		6,627	16
17	REWIRE 15 ROOMS			1998	10,400	267	39	267		1,768	17
18	MASTER POWER PANEL, CONTROL			1998	5,994	154	39	154		1,020	18
19	DOORS			1998	2,941	75	39	75		478	19
20	INSTALL VENTILATION FOR ELEVATOR ROOM			1998	8,750	224	39	224		1,428	20
21	INSTALL RETURN PIPES & SINKS			1998	4,752	122	39	122		747	21
22	ACCESS PANELS			1998	1,378	35	39	35		214	22
23	DIETARY DOOR & FRAME			1998	2,042	52	39	52		319	23
24	MIXING VALVES			1999	5,000	128	39	128		709	24
25	DRAIN			1999	5,523	142	39	142		787	25
26	WATER METER			1999	8,998	231	39	231		1,280	26
27	FRAMES, DOORS			2000	10,451	380	27.5	380		1,726	27
28	EXHAUST FAN & FIRE DAMPERS			2000	4,600	167	27.5	167		759	28
29	BOOSTER PUMP SYSTEM			2000	18,000	655	27.5	655		2,975	29
30	MIXING VALVES			2000	4,215	153	27.5	153		695	30
31	HOT WATER SUPPLY SYSTEM			2001	8,748	318	27.5	318		1,126	31
32	PAINTING			2001	32,000	1,164	27.5	1,164		4,122	32
33	STORAGE TANK			2001	3,340	121	27.5	121		429	33
34	ELEVATOR REHAB			2001	9,465	344	27.5	344		1,219	34
35	RE-WIRE FIRE ALARM SYSTEM			2002	4,645	169	27.5	169		430	35
36	HOT WATER BOILER			2002	9,448	344	27.5	344		874	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	LOBBY AIR CONDITIONING AND COMPRESSOR	2002	\$ 7,594	\$ 276	27.5	\$ 276	\$	\$ 702	37
38	INSULATED GLASS	2002	3,275	119	27.5	119		303	38
39	DOOR REPLACEMENT	2002	4,490	163	27.5	163		414	39
40	PUMPS	2002	3,721	135	27.5	135		343	40
41	PIPING, BALL VALVE, AND FITTINGS	2002	5,491	200	27.5	200		508	41
42	HOT WATER HEATER	2002	2,000	73	27.5	73		185	42
43	WINDOWS AND DOORS	2003	27,230	990	27.5	990		1,526	43
44	HEATING & COOLING CHASSIS	2003	7,142	260	27.5	260		401	44
45	DOOR ALARM	2003	1,515	55	27.5	55		85	45
46	TILING	2003	2,328	85	27.5	85		131	46
47	2 HOT WATER HEATERS (WESTSHIRE PROPERTIES)	2004	22,404	577	27.5	577		577	47
48	VERTICAL PUMPS(WESTSHIRE PROPERTIES)	2004	5,860	151	27.5	151		151	48
49	NEW CONDUIT(WESTSHIRE PROPERTIES)	2004	3,160	81	27.5	81		81	49
50	PLUMBING(WESTSHIRE PROPERTIES)	2004	15,337	395	27.5	395		395	50
51	COMPRESSOR(WESTSHIRE PROPERTIES)	2004	11,023	217	27.5	217		217	51
52	ELEVATOR(WESTSHIRE PROPERTIES)	2004	38,820	412	27.5	412		412	52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 20,031,570	\$ 514,805		\$ 514,805	\$	\$ 4,259,287	70

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)								
	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$866,813	\$55,605	\$86,681	\$31,076	10 YRS	\$566,813	71
72	Current Year Purchases	37,470	22,482	1,874	(20,608)	10 YRS	1,874	72
73	Fully Depreciated Assets							73
74	REL PARTY	1,455,000	145,500	145,500		10 YRS	1,236,750	74
75	TOTALS	\$2,359,283	\$223,587	\$234,055	\$10,468		\$1,805,437	75

D. Vehicle Depreciation (See instructions.)*									
	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9
76				\$	\$	\$	\$		\$
77									
78									
79									
80	TOTALS			\$	\$	\$	\$		\$

E. Summary of Care-Related Assets					1	2
		Reference				Amount
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)			\$	22,510,853
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	738,392
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	748,860
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	10,468
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	6,064,724

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)				
	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4
86		\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92		\$
93		
94		
95		\$

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease
-

9. Option to Buy:
- ☐ YES☐ NO
- Terms:
- *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?
- ☐ YES☐ NO
16. Rental Amount for movable equipment: \$68,517
- Description: SEE SCHEDULE ATTACHED

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	RESIDENT TRANSP.	2001 CHEVY VAN	\$829.20	\$6,716	17
18	ADMINISTRATION	2005 MERCED.E CLASS	800.00	4,228	18
19	RESIDENT TRANSP.	2004 CHEVY VAN		1,803	19
20	ADMINISTRATION	2003 JAGUAR S TYPE	899.00	10,554	20
21	TOTAL		\$#####	\$23,301	21

10. Effective dates of current rental agreement:

Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	\$
13.	/2006	\$
14.	/2007	\$

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER AIDE

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER AIDE

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

B. EXPENSES

C. CONTRACTUAL INCOME

D. NUMBER OF AIDES TRAINED

ALLOCATION OF COSTS (d)

In the box below record the amount of income your facility received training aides from other facilities.

		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-8	hrs	\$		\$ 73,009	\$		\$ 73,009	1
2	Licensed Speech and Language Development Therapist	39-8	hrs			1,080			1,080	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-8	hrs			99,548			99,548	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-8	# of prescrpts				63,838		63,838	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Rentals, Other Serv.	39-8				39,836	5,720		45,556	13
14	TOTAL			\$		\$ 213,473	\$ 69,558		\$ 283,031	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 171,224	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	3,936,560		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	229,553		6
7	Other Prepaid Expenses	4,038		7
8	Accounts Receivable (owners or related parties)	279,372		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,620,747	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	325,186		15
16	Equipment, at Historical Cost	1,049,567		16
17	Accumulated Depreciation (book methods)	(1,027,026)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 347,727	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,968,474	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,981,972	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	2,347,000		29
30	Accrued Salaries Payable	360,228		30
31	Accrued Taxes Payable (excluding real estate taxes)	27,557		31
32	Accrued Real Estate Taxes(Sch.IX-B)	718,586		32
33	Accrued Interest Payable	100,338		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Due To Members</u>	300,000		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 5,835,681	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 5,835,681	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (867,207)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,968,474	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,401,263	1
2	Restatements (describe):		2
3	POST CLOSING ENTRIES	(784,254)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,617,009	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(2,484,216)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (2,484,216)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (867,207)	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 11,430,487	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 11,430,487	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	206,806	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 206,806	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 11,637,293	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,796,453	31
32	Health Care	4,654,001	32
33	General Administration	3,004,726	33
	B. Capital Expense		
34	Ownership	3,117,032	34
	C. Ancillary Expense		
35	Special Cost Centers	283,031	35
36	Provider Participation Fee	266,266	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 14,121,509	40
41	Income before Income Taxes (line 30 minus line 40)**	(2,484,216)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (2,484,216)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

TAX RETURN NOT FINISHED

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,082	2,222	\$ 71,468	\$ 32.16	1
2	Assistant Director of Nursing	1,927	2,105	61,753	29.34	2
3	Registered Nurses	16,735	18,024	495,979	27.52	3
4	Licensed Practical Nurses	54,016	58,436	1,187,692	20.32	4
5	Nurse Aides & Orderlies	141,504	151,080	1,543,829	10.22	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	10,288	11,445	195,042	17.04	8
9	Activity Director	1,936	2,097	34,196	16.31	9
10	Activity Assistants	16,058	17,199	153,139	8.90	10
11	Social Service Workers	16,977	18,310	226,947	12.39	11
12	Dietician					12
13	Food Service Supervisor	11,301	12,515	211,196	16.88	13
14	Head Cook					14
15	Cook Helpers/Assistants	42,497	45,529	369,702	8.12	15
16	Dishwashers					16
17	Maintenance Workers	13,455	14,150	198,519	14.03	17
18	Housekeepers	41,053	44,155	399,538	9.05	18
19	Laundry	14,477	16,119	160,987	9.99	19
20	Administrator	2,381	2,674	125,751	47.03	20
21	Assistant Administrator					21
22	Other Administrative	1,939	2,223	236,179	106.24	22
23	Office Manager	1,973	2,227	87,620	39.34	23
24	Clerical	18,808	20,543	349,673	17.02	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	14,053	15,240	206,968	13.58	31
32	Other Health C: Supply/nrsg clerk	10,665	11,403	138,734	12.17	32
33	Other(specify) Security Service	13,859	14,884	132,337	8.89	33
34	TOTAL (lines 1 - 33)	447,984	482,580	\$ 6,587,249 *	\$ 13.65	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	M	\$ 13,440	1-3	35
36	Medical Director	O	21,765	9-3	36
37	Medical Records Consultant	N	2,516	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	6,185	10-3	39
40	Physical Therapy Consultant	L	306	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	448	11-3	44
45	Social Service Consultant	E	10,854	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 55,514		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$ 0	10-3	50
51	Licensed Practical Nurses		0	10-3	51
52	Nurse Aides	79	1,965	10-3	52
53	TOTAL (lines 50 - 52)	79	\$ 1,965		53

* This total must agree with page 4, column 1, line 45.

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description		Amount	Description	Amount
MARY ANN WRIGHT	ADMIN		\$ 125,751	Workers' Compensation Insurance	\$	128,357	IDPH License Fee	\$
ZINA WARD	OPERATIONS DIRECTOR		236,179	Unemployment Compensation Insurance		135,479	Advertising: Employee Recruitment	29,733
				FICA Taxes		490,300	Health Care Worker Background Check	4,511
				Employee Health Insurance		335,089	(Indicate # of checks performed)	
				Employee Meals		31,622	MARKETING/ADV/PROMO	250,884
				Illinois Municipal Retirement Fund (IMRF)*			TRUST/FRANCHISE/CONTRIB/ETC	14,230
				EMPLOYEE BENEFITS - OTHER		10,951	LICENSES & PERMITS	11,732
				EMPLOYEE PHYSICAL EXAMS		1,818	DUES & SUBSCRIPTIONS	19,528
				PENSION/PROFIT SHARING PLANS		48,925	MGMT CO ALLOCATION	
TOTAL (agree to Schedule V, line 17, col. 1)				CHICAGO HEAD TAX		0	TRUST/FRANCHISE/CONTRIB/ETC	(14,230)
(List each licensed administrator separately.)			\$ 361,930	INSURANCE - EXECUTIVE LIFE		0	Less: Public Relations Expense	(0)
B. Administrative - Other							Non-allowable advertising	(250,884)
Description			Amount	INSURANCE - EXECUTIVE LIFE VI 21		0	Yellow page advertising	(0)
			\$ 0					
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL (agree to Schedule V,		\$ 1,182,541	TOTAL (agree to Sch. V,	
(Attach a copy of any management service agreement)				line 22, col.8)			line 20, col. 8)	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
			\$			\$	Out-of-State Travel	\$
							In-State Travel	
								0
							Seminar Expense	
								0
SEE SCHEDULE ATTACHED			313,018				Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	(agree to Sch. V,	
(If total legal fees exceed \$2500 attach copy of invoices.)			\$ 313,018				line 24, col. 8)	\$

* Attach copy of IMRF notifications

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	PAINTING/DECORATING	06/00	\$ 3,547	3 YRS	\$ 1,182	\$ 1,182	\$ 592	\$	\$	\$	\$	\$	\$
2	PAINTING/DECORATING	06/03	3,249	3 YRS			541	1,083	1,083	542			
3	PAINTING/DECORATING	06/04	22,452	3 YRS				7,484	3,742	3,742	7,484		
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 29,248		\$ 1,182	\$ 1,182	\$ 1,133	\$ 8,567	\$ 4,825	\$ 4,284	\$ 7,484	\$	\$

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IL COUNCIL LONG TERM CARE \$18,091
- (3) Did the nursing home make political contributions or payments to a political organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 11,942 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO _____ If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 266,266
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 31,622 Has any meal income been offset against related costs? _____ Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees